

CNA/HHA REPORT OF MISCONDUCT

To: California Department of Health Services
Licensing and Certification Program (L&C)
Investigation Section, MS 3303
1615 Capitol Avenue
P.O. Box 997416
Sacramento, CA 95899-7416
(916) 552-8883
FAX: (916) 552-8788

From reporting party:

Name: _____

Address: _____

Telephone: _____

Date sent to DHS		Date received		Complaint number (Department use only)	
Name of CNA/HHA			Certification number		Social Security number
AKA			Phone number ()		
Address (number, street)			City	State	ZIP code
Complainant name (if different from reporting party)			Relationship		Phone number ()
Address (number, street)		City	State	ZIP code	Requesting anonymity? <input type="checkbox"/> Yes <input type="checkbox"/> No

Complaint (Brief description and date of incident). Use reverse if more space is needed.

If available, please provide the following information:

1. Copies of any investigation reports initiated by the facility, district office, law enforcement agency, or any other agency.
2. Copies of any signed witness/resident statements which pertain to this incident.
3. Copies of any previous incidents and employee disciplinary action.
4. Names and addresses of any law enforcement agency or other agency to whom this was reported. (Please list all referrals/reports on the reverse side of this form.)

Employer name		Phone number ()	
Address (number, street)		City	State ZIP code
Administrator name		Action taken: <input type="checkbox"/> Termination <input type="checkbox"/> Suspension <input type="checkbox"/> None	

Reported to:

LICENSING AND CERTIFICATION DISTRICT OFFICE		Date	
Address (number, street)	City	State	ZIP code
Name of individual reported to		Phone number ()	
Complaint investigation conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____			

LAW ENFORCEMENT AGENCY		Date	
Address (number, street)	City	State	ZIP code
Name of individual reported to		Phone number ()	
Complaint investigation conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____		Did it result in an arrest? <input type="checkbox"/> Yes <input type="checkbox"/> No	Report number

OMBUDSMAN		Date	
Address (number, street)	City	State	ZIP code
Name of individual reported to		Phone number ()	
Complaint investigation conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____			

BUREAU OF MEDI-CAL FRAUD		Date	
Address (number, street)	City	State	ZIP code
Name of individual reported to		Phone number ()	
Complaint investigation conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____			

Complaint description (continued)

Note: Reports made to the Investigation Section will be coordinated with other agencies